STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. BUILDING _____ B. WING _____	01/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT LEBANON	1585 PERRY WORTH RD LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure survey. Survey dates: January 18, 19, 20, 21, and 24, 2011 Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470 Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Census bed type: SNF/NF--47 Total--47 Census payor type: Medicare--5 Medicaid--38 Other--4 Total--47 Sample: 12 Supplemental Sample: 3 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on January 28, 2011 by Bev Faulkner, RN	F 000	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on February 23, 2011.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if	F 157	**F157** **It is the policy of this facility to ensure that the resident; consult with the resident's physician; and if, known notify the resident's legal representative ....when there is a significant change in the resident's physical, mental or psychosocial**	

RECEIVED
FEB 18 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

addendum received 02-24-11 R. Osmon
addendum approved 03-03-11 RL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the attending physician about the development of a green sputum drainage from a tracheostomy, for 1 of 12 residents reviewed for physician notification; in a survey sample of 12 residents reviewed. [Resident #27]	F 157	**status in either life threatening conditions or clinical complications** **<u>1.What corrective action will be done by the facility?</u>** **Nurses and nursing assistants have been provided education as to what signs and symptoms of an infection in a tracheostomy might be and the appropriate physician notifications and responsible party/family notifications to be made.** **In addition to the above an inservice for licensed nurses and QMAs is scheduled for February 16, 2011 on the facility policy and procedure for "Change in Condition", including notifying the resident physician and resident's legal representative/family.** **The CNA assignment sheet has been updated to include common signs/symptoms of infection in a tracheostomy and to notify the**	

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F 157	Continued From page 2 Findings include: 1. The "Lippincott Manual of Nursing Practice" Fifth Edition, 2008 indicated that the signs and symptoms of infection in a tracheostomy were listed as: " Watch for color variations. White or translucent color is normal; discolored secretions(yellow or green could indicate infection). The clinical record for Resident #27 was reviewed on 1/20/11 at 2:45 P.M. Diagnoses included, but were not limited to, anoxic brain injury, encephalopathy, persistent vegetative state, and tracheotomy. Nursing progress notes, dated for the month of September, 2010, indicated resident had white mucous secretions from the tracheostomy. Nursing progress notes, dated October 2010 through January 4, 2011, indicated yellow mucous secretions from the tracheostomy. No green mucous was noted. A Nursing note, dated 1/5/11 at 8:00 P.M., indicated "... suctioned x [times] 2 this shift noted sm [small] amt [amount] of green mucous with suctioning...." A Nursing note, dated 1/6/11 at 9:00 P.M., indicated "... Trach care complete suction x 2 scant amt green mucous noted...." There was no indication that the physician had been notified regarding the green mucous. The patient was hospitalized 1/11/11. An acute care hospital History and Physical, dated 1/12/11, indicated "... patient on afternoon	F 157	**nurse of s/s of infection in tracheostomy.** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **No other residents were affected.** **The licensed nurses and nursing assistants shall receive inservice education as to what signs and symptoms of an infection in a tracheostomy might be, the policy and procedure for change in condition, and the appropriate physician and resident legal representative/family notification.** **As stated above, on February 16, 2011 nursing staff shall be inserviced/educated on the facility policy and procedure for "Change in Condition", including notification of the physician and resident's legal**	

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F 157	Continued From page 3 of admission had a sudden spike in temperature of 104 without any symptomatology...Chest x-ray showed some bibasilar atelectasis...white count 13,000 with normal differential.... PHYSICAL EXAMINATION: ... CHEST: Rhonchi and rales, particularly in the right base. There is no respiratory distress.... ASSESSMENT: Fever, possible aspiration or atelectasis...." During an interview on 1/24/11 at 10:40 A.M., the Director of Nursing indicated that yellow, green and brown sputum in not uncommon for Resident #27 to have from his tracheostomy, and that she would have expected the nurse to call her so that she could evaluate the resident. There was no documentation/evidence that the Director of Nursing had been notified of the green mucous or documentation the physician had been aware.	F 157	**representative/family.** **3.What measures will be put into place to ensure this practice does not recur?** **Both licensed and unlicensed nursing staff shall be inserviced on the facility policy and procedure for change in resident condition, including notification of the attending physician and resident's legal representative, and signs and symptoms of infection in a tracheostomy.**	
F 246 SS=E	3.1-5(a)(2) 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that individual call light devices were within reach and available to summon staff for assistance, for 4 of 12 survey sample residents reviewed [Residents #15, #18,	F 246	**At least 5 days per week, the Director of Nurse's or designee will review the 24-hour report, the focus charting and any other associated documentation to identify any resident with signs and symptoms of infection, including the tracheostomy.** **If the DON or designee finds that a resident is showing signs and symptoms of infection she will**	

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F 246	Continued From page 4 #21, and #40]; and 1 of 3 supplemental residents observed. [Resident #38] Findings include: 1. The clinical record review for Resident #18 was reviewed on 1/19/11 at 9:40 A.M. Diagnoses included, but were not limited to, diabetes, dementia, multiple strokes with dysphagia, chronic kidney disease, and contractures of upper and lower extremities. On 1/19/11 at 9:20 A.M., the resident was observed in bed, turned onto his right side. A left arm/elbow splint was in place on his left upper extremity. The resident's call light cord and button device was observed draped over the post on the right side of the head-board [looking from the foot of the bed], with the call button hanging down to the floor. The device was behind, and to the left of, the resident. When asked at that time if he knew where his call light was, the resident responded by shaking his head "no." On 1/20/11 at 9:00 A.M., the resident was observed in bed, on his right side with the splint in place on his left arm and elbow. The call light cord and button were laying on the floor and at the right side of the head of the bed. At 10:48 A.M., the resident was observed in bed, on his right side with the left arm splints in place. The call light cord was clipped to the bed covers at the left side of the resident's torso, and slightly behind his left arm.	F 246	**make sure that the resident's needs are taken care of and then ensure the physician and resident's legal representative/family is notified of the change in condition** **Once that is assured, the DON will re-train any nursing staff involved and will dispense progressive disciplinary action, up to and including termination, for continued instances of noncompliance.** **Reviews done by the DON or designee will be documented on the QA Audit Tool -157.** **The process and review will continue on an ongoing basis. Results of the 5 day per week review of the 24 hour report and focus charting is reviewed with the IDT at the stand-up meeting 5 days per week.**	

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F 246	Continued From page 5 When asked at 10:48 A.M., if he knew where his call light was, the resident again shook his head "no." On 1/20/11 at 11:45 A.M., the resident was observed in bed, laying on his left side. The call light cord and button was laying on the floor. When asked at that time if he would be getting up for lunch, he responded "I think so." On 1/20/11 at 2:27 P.M., the resident was observed in bed, laying on his back. The call light cord and button was laying on the floor between the head of the bed and the wall. 2. The clinical record for Resident #15 was reviewed on 1/21/11 at 10:40 A.M. Diagnoses included, but were not limited to, osteoarthritis, depressive disorder, heart disease, hypertension, peripheral vascular disease, and obesity. On 1/19/11 at 9:30 A.M., the resident was observed in a recliner chair in her room, with the foot rest elevated. The call light device was located wrapped up in the blankets on her bed, which was positioned in the opposite corner of the room, and out of her reach. In an interview at that time, the resident stated, "They [staff] don't always put it where I can reach it. I'll tell them next time someone comes in." 3. The clinical record for Resident #21 was reviewed on 1/20/11 at 2:40 P.M. Diagnoses included, but were not limited to, degenerative joint disease, ischemic heart disease, depression, and dementia with behavioral disturbance. On 1/19/11 at 1:45 P.M., the resident was	F 246	**4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.** **While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.**	

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F 246	Continued From page 6 observed laying in bed, with the bed positioned parallel to, and against the wall. The call light cord and button was observed laying on the floor underneath the foot of the bed. At 2:50 P.M., the resident was observed laying in bed. The call light cord was observed connected to the outlet at the wall, but button could not be found. In an interview at that time, the resident indicated she did not know where it was, and was not sure how to call for assistance. On 1/20/11 at 10:40 A.M., the resident was observed in bed. The call light cord and button was observed on the floor, underneath the foot of the bed. In an interview at that time, the resident indicated she did not know where her call light was. At 11:05 A.M., the resident was observed while receiving hygiene care. The resident was observed sitting on a bedside commode next to her bed. L.P.N. #1 told the resident "Next time, tell me if you need help." The resident's call light cord and button were observed to be on the floor underneath the foot of the bed. After providing hygiene care, L.P.N. #1 hunted for and found the call light cord and button under the bed. She held it up in front of the resident and told her to push the button when she needed help. The resident said, "Oh, isn't that interesting." 4. During the initial tour on 1/18/11 at 9:50 A.M., L.P.N.#3 indicated Resident #38 had fallen two weeks ago. On 1/19/11 at 1:40 P.M., Resident #38 was observed lying on his left side in bed. The call light was wrapped above the head of the bed and not within reach of the resident.	F 246	**Date of Compliance: February 23, 2011.** **F246** **It is the policy of this facility to ensure that the resident's right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered** **1.What corrective action will be done by the facility?** **Nursing staff shall be inserviced/educated on the facility policy and procedure for call-lights on February 16, 2011** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?**	

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F 246	Continued From page 7 On 1/20/11 at 8:52 A.M. and 10:45 A.M., Resident #38 was observed in bed, lying on his right side. The call light was wrapped in a loop above the resident's head of bed. During the environmental tour of facility on 1/20/11 at 2:15 PM., with the Maintenance Manager and the Assistant Director in attendance, Resident #38 was observe to be laying in bed. When requested to push his call light, the resident indicated he did not know where it was. When told it was above his bed and asked if he could reach it, the resident indicated he could not. 5. During the initial tour on 1/18/11 at 9:50 A.M., L.P.N. #3 indicated that Resident #40 had a history of falls. The clinical record for Resident #40 was reviewed on 1/19/11 at 9:15 A.M. An initial care plan, dated 12/16/10 and provided by the Director of Nursing on 1/21/11 at 8:50 A.M., addressed a problem of "Risk for Falls." One intervention was listed as: "...call light in reach..." On 1/20/11 at 1:42 P.M., the resident was observed in her chair next to her bed. Her head was in her hands, and she had her eyes closed. Her left leg wrapped underneath her right. The call light was observed behind the resident's chair. 3.1-3(v)(1)	F 246	**No other resident's were affected.** **3.What measures will be put into place to ensure this practice does not recur?** **As stated above nursing staff shall be inserviced/educated on the facility policy and procedure for call-lights on February 16, 2011** **In addition to the above residents #15, #18, #21, #40 and #38 will be checked every shift for 2 weeks, 5 times weekly for 2 weeks and weekly for 2 weeks to be sure their call lights are within their reach when they are in their rooms. Disciplinary action will be initiated for any associate found to not have placed the call lights appropriately.** **The Director of Nurse's or designee will conduct daily and frequent administrative rounds to**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 8 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain floor and stand fans, used in 1 of 2 resident rooms, in a clean and sanitary condition; in a survey sample of 12 residents reviewed. [Resident #27] Findings include: 1. In an interview during the initial tour on 1/18/11 at 9:50 A.M., L.P.N. #3 indicated that Resident #27 had just gotten out of the hospital, and that the resident required a tracheostomy for breathing. On 1/20/11 at 3:30 P.M., three fans were observed to be circulating air in the resident's room. All of these were pointed toward the resident. The fans were covered in gray fuzzy matter. One fan was on the floor, one was on a miniature refrigerator that was in the room, one was on a shelf to the right above the resident's head of bed. In an interview on 1/19/11 at 9:20 A.M., a family member indicated that these fans were running most of the time because the resident becomes easily overheated, and he needs the fans to stay cool. 3.1-19(f)	F 253	**ensure call-lights are within reach when residents are in their rooms.** **If the DON or designee finds that a resident is in their room and the call-light is not within reach the DON or designee will make sure that the resident's needs are taken care of and then ensure the call-light is within reach.** **Once that is assured, the DON will re-train any nursing staff involved and will dispense progressive disciplinary action, up to and including termination, for continued instances of noncompliance.** **Reviews done by the DON or designee will be documented on the QA Audit Tool 246.** **The process and review will continue on an ongoing basis. The results of the administrative rounds checking for call-light**	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272		

placement will occur 5 days per week and the results will be reviewed with IDT at the stand-up meeting 5 days per week.

4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.

While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days.

Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.
Date of Compliance: February 23, 2011.

F253

It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

What corrective action will be done by the facility?

The fan in resident # 27's room and all other fans in resident's rooms were checked and cleaned during the survey.

Fans in resident rooms shall be added to monthly cleaning schedule for monthly cleaning .

2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?

No other resident was affected, however every resident with a fan in his/her room has the potential to be affected.

Residents with fans in their rooms will have the fan cleaned at least monthly. The cleaning of resident fans has been added to the monthly cleaning schedule.

3.What measures will be put into place to ensure this practice does not recur?

The Administrator, Director of Maintenance and Housekeeping, and Director of Nursing provided an inservice/education on the importance of providing a sanitary, orderly and comfortable interior for the residents, including

the importance of cleaning resident fans.

Residents with fans in their rooms will have the fan cleaned at least monthly. The cleaning of resident fans has been added to the monthly cleaning schedule.

During daily and frequent administrative rounds the administrator, Director of Maintenance and Housekeeping, or designee shall monitor the facility and resident rooms to ensure a sanitary, orderly, and comfortable interior, including fans.

Each month after resident fan have been cleaned the Director of Maintenance and Housekeeping will update the IDT during the IDT meeting 5 days per week.

Documentation of cleaning the resident fans shall be documented on the monthly cleaning schedule.

4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Administrator, Director of Maintenance, or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.

Date of Compliance: February 23, 2011.

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F 272	Continued From page 9 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to comprehensively assess signs and symptoms of a U.T.I. [urinary tract infection] before and after antibiotic treatment was instituted, for 1 of 1 resident who had a recurrent	F 272	**F 272** **It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity** **What corrective action will be done by the facility?** **Nursing staff shall be inserviced/educated on the facility policy and procedure for change in condition, including identifying signs and symptoms of urinary tract infections (UTI).** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **No other residents were affected.**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10 U.T.I.; in a survey sample of 12 residents reviewed. [Resident #18] Findings include: The clinical record for Resident #18 was reviewed on 1/19/11 at 9:40 A.M. Diagnoses included, but were not limited to, diabetes, multiple strokes with dysphagia (difficulty swallowing) and contractures, dementia, nephritis, chronic kidney disease, and history of a transurethral resection of the prostate surgery. An acute care hospital discharge summary, dated 2/17/10, indicated, "... U.T.I. [urinary tract infection]--would consider urology consult since this is patient's 4th admit in last 9 months for U.T.I.. Acute or chronic renal failure...." On 10/21/10, the attending physician ordered a U.A. [urinalysis] with a C. & S. [culture and sensitivity] laboratory test. The "Nurse's Notes" from 10/1/10 through 10/18/10 had no documentation of any signs or symptoms of a U.T.I. A "Nurse's Notes" entry, dated 10/21/10 at 2:00 P.M., indicated "Reported labs with new order received. U.A. obtained and lab notified." In an interview on 1/21/11 at 9:15 A.M., the Director of Nursing indicated the resident had a diagnosis of "asymptomatic bacteremia" listed on the January 2011 physician order recap [recapitulation] sheet. She indicated she could not locate any other information related to symptoms, or why the U.A. was ordered. She believed a routine blood test result showed an elevated white blood cell count, which may have prompted the physician to order the U.A.	F 272	**As stated above, the nursing staff shall be inserviced/educated on the facility policy and procedure for change in condition, including identifying signs and symptoms of urinary tract infections (UTI).** **The facility wishes to point out that the surveyor was provided information that resident #18 has a diagnosis of asymptomatic bacteremia. Without symptoms it would have been difficult for any nurse to have documented symptoms in the chart.** **3.What measures will be put into place to ensure this practice does not recur?** **Both licensed and unlicensed nursing staff shall be inserviced on the facility policy and procedure for change in resident condition, including notification of the attending physician and resident's legal representative, and signs and**	

symptoms of urinary tract infections (UTI).

At least 5 days per week, the Director of Nurse's or designee will review the 24-hour report, the focus charting and any other associated documentation to identify any resident with signs and symptoms of infection, including signs and symptoms of urinary tract infections (UTI). If the DON or designee finds that a resident is showing signs and symptoms of infection she will make sure that the resident's needs are taken care of and then ensure the physician and resident's legal representative/family is notified of the change in condition

Once that is assured, the DON will re-train any nursing staff involved and will dispense progressive disciplinary action, up to and including termination, for

continued instances of noncompliance.

Reviews done by the DON or designee will be documented on the QA Audit Tool -272.

The process and review will continue on an ongoing basis. The results of the 5 day per week review of the 24 hour report and focus charting is reviewed with IDT at the stand-up meeting 5 days per week.

4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for

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F 272	Continued From page 11 Between 10/24 and 11/17/10, the physician ordered three different antibiotics and subsequent repeat U.A.s. "Nurse's Notes" progress notes from 10/23 through 11/17/10 had documentation the resident had no adverse side effects from the antibiotic treatment and was tolerating antibiotic treatment well, with an occasional recorded normal temperature. There was no comprehensive assessment information related to signs and symptoms of a urinary tract infection. In an interview on 1/21/11 at 9:15 A.M., the Director of Nursing indicated she was unable to locate any documentation related to a comprehensive assessment of signs and symptoms of a urinary tract infection for this resident. 3.1-31(c)(6)	F 272	**improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.** **While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.** **Date of Compliance: February 23, 2011.**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	**F279** **It is the policy of this facility to provide services by qualified persons in accordance with each resident's written plan of care.** **What corrective action will be done by the facility?**	

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F 279	Continued From page 12 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that 1 of 1 resident had care plan entries addressing issues relating to falls, seizures, and nutrition. This impacted 1 of 12 residents in a sample of 12 (Resident #40) Findings include: In an interview during the initial tour on 1/19/11 at 9:50 A.M., L.P.N. #3 indicated that Resident #40 had behavioral issues, mental retardation, Down's syndrome, a fall history and a Wanderguard (device to prevent elopement). The clinical record was reviewed on 1/19/11 at 9:15 A.M. Diagnoses included, but were not limited to, seizures, dementia, moderate mental retardation, and Down's syndrome. The Pre-Admission Screen II, dated 10/24/10, indicated the resident had a history of seizures. An "Initial Care Plan," dated 12/16/10, listed a section addressing "Safety." For a problem of "History of falls," with the interventions listed as: "Call light in reach; orient to new surroundings and staff." The entry was to be reviewed in 21	F 279	**On February 16, 2011 the licensed nurses and Dietary Services Manager will receive inservice/education on completing accurate assessments and care plans, as well as the frequency, method, and timeliness required to update care plans and interventions as the resident assessment is complete.** **Care plans for falls, seizures, weight loss, diet as ordered and nutrition have been developed and added for resident #40.** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **The licensed nurses and Dietary Services Manager will receive inservice/education on completing accurate assessments and care plans, as well as the frequency, method, and timeliness required to**	

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F 279	Continued From page 13 days. A subsequent updated care plan was not located. For a problem of "At risk for weight loss," the interventions were listed as: "Will consume 50 % of each meal every day; Monitor intake and output every shift; Monitor weight weekly x (times) 4; Provide diet as ordered." This section was also to be reviewed in 21 days. A subsequent updated care plan was not found. There was no care plan addressing seizures. On 1/18/11 at 2:35 P.M., Resident #40 was observed in her room. Her eyes appeared droopy and she slurred her words when she spoke. On 1/19/11 9:13 A.M., the resident was observed at the nurses' station, and then wandering the halls between her room, the nurses station, and dining room area. On 1/20/11 at 1:42 P.M., the resident was observed in her chair next to her bed with her head in their hands and eyes closed with her left leg wrapped underneath her right. Call light observed behind the resident's chair. During the daily conference on 1/20/11 at 3:45 P.M., the Director of Nursing was given the opportunity to submit any care plan entries addressing the issues of seizures, falls, and nutrition. On 1/21/11 at 9:00 A.M., the Director of Nursing indicated the resident's admission M.D.S. [Minimum Data Set] assessment was recently completed, and the appropriate disciplines were currently working on the care plan entries.	F 279	**update care plans and interventions as the resident assessment is complete.** **Care plans for falls, seizures, weight loss, diet as ordered and nutrition have been developed and added for resident #40.** **3.What measures will be put into place to ensure this practice does not recur?** **No other residents were affected. Newly admitted residents within the last 60 days have had their medical record and care plan audited to ensure complete and accurate assessments have been completed.** **In addition, an audit was completed to ensure a comprehensive care plan for each resident, including measureable objectives and timetables to meet the resident's need was developed.**	

Care plans will be audited by the Director of Nurse's or designee between the 14th and 21st days after admission for completeness and accuracy.

Results of the audits done by the Director of Nurse's or designee will be documented using the Clinical Record Admission Audit tool or the On-Going Clinical Record Audit tool.

The process and review will continue on an ongoing basis. The results of the audits will be reviewed with the IDT at the stand-up meeting 5 days per week.

4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The

committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.

While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.
Date of Compliance: February 23, 2011.

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It is the policy of this facility to provide services by qualified persons in accordance with each resident's written plan of care.

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F 279	Continued From page 14 3.1-35(b)(1)	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the physician's orders regarding weekly blood pressure checks, physician call parameters for blood pressure medication, the discontinuation of an antidepressant medication, the increase of an antidepressant medication, the use of an alarming seatbelt, diet and lab orders. This impacted 6 of 12 residents reviewed for following physician's orders in a sample of 12. (Residents #11, #13, #15, #16, #18 and #23) Findings include: 1. The clinical record of Resident #11 as reviewed on 1/19/11 at 2:00 P.M. Diagnoses for Resident #11 included, but were not limited to, dementia, Parkinson's disease and depression A physician's order, dated 9/22/10, indicated, "dc (discontinue) Remeron 7.5 mg [anti-depressant] (milligrams)." A review of the Medication Administration Records (MAR) for the months of October and November 2010, indicated Resident #11 received the last dose of Remeron on November 15, 2010.	F 282	**What corrective action will be done by the facility?** **Licensed nursing staff shall receive inservice/education on following physician orders regarding weekly blood pressure checks, physician call parameters for blood pressure medication, the discontinuation and/or change in medication, and processing lab orders.** **Both licensed and unlicensed nursing staff shall be inserviced/educated of the use of alarming seat belts** **The Dietary Services manager has added the physician's order for cottage cheese to the diet card and meal slips. .** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?**	

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F 282	Continued From page 15 The Remeron 7.5 mg was not discontinued as ordered on September 22, 2010. During an interview with the Director of Nursing (DoN), on 1/20/11 at 10:15 A.M.. she indicated the did receive the Remeron 7.5 mg and that it was not stopped until mid November. 2. The clinical record of Resident #16 was reviewed on 1/24/11 at 10:00 A.M. Diagnoses for Resident #16 include, but were not limited to, bipolar depression, dementia, Macular degeneration and osteoarthritis. A physician's order, dated 11/10/10, indicated, "D/C pressure alarm for chair et [and] use alarming self-release seat belt while up in w/c [wheelchair]." During an observation, on 1/21/11 at 2:00 P.M., Resident #16 was observed sitting in her wheelchair, in her room. The seatbelt was open, with the ends laying along the Resident's upper thighs. There was no alarm sounding. During an interview on 1/24/11 at 10:30 A.M., the Director of Nursing indicated that at the time of the observation on 1/21/11 at 2:00 P.M., the seat belt did not have an alarm. She indicated the alarm for the seatbelt had to be ordered, and nursing was not notified when the alarm had come in. It was now placed on the wheelchair. 3. The clinical record of Resident #13 was reviewed on 1/19/11 at 10:00 A.M. Diagnoses for Resident #13 included, but were not limited to, high blood pressure, glaucoma, Alzheimer's diease and diabetes.	F 282	**No other resident was affected.** **Licensed nursing staff shall receive inservice/education on following physician orders regarding weekly blood pressure checks, physician call parameters for blood pressure medication, the discontinuation and/or change in medication, and processing lab orders.** **Both licensed and unlicensed nursing staff shall be inserviced/educated of the use of alarming seat belts** **3.What measures will be put into place to ensure this practice does not recur?** **Physicians were contacted and orders were clarified on blood pressure checks, call parameters on blood pressure medication, the correct dosage of medication, the use of an alarming seatbelt, diet orders and lab orders.**	

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F 282	Continued From page 16 A physician's order, dated 1/25/07, indicated weekly blood pressure were to be done on Saturdays. A review of the MAR dated for the month of December 2010, indicated the Resident's blood pressure was not checked on December 12th, 19th or 26th. During an interview on 1/24/11 at 10:00 A.M., the Director of Nursing indicated blood pressure checks were supposed to be documented on the MAR. No further information was submitted prior to exit regarding the monitoring of the blood pressures. 4. The clinical record of Resident #23 was reviewed on 1/21/11 at 10:30 A.M. Diagnoses for Resident #23 included, but were not limited to, high blood pressure, Alzheimer's diseases and depression. A physician's order, dated 4/24/03, indicated " blood pressure, check weekly on Thursday. Call if SBP [systolic blood pressure] < [less than] 10 or > [greater than] 150, or DBP [diastolic blood pressure] < 60 or > 90." A review of the MAR for the month of November 2020, indicated the Resident's blood pressure was not checked November 18th and 25th. During an interview on 1/24/11 at 10:00 A.M., the Director of Nursing indicated blood pressure checks were supposed to be documented on the MAR. No further information was submitted prior to exit regarding the monitoring of the blood pressures.	F 282	**Resident #11 had the medication discontinued.** **Resident #15 had the correct dose of medication clarified and that dosage is being administered.** **Medication Administration Records have been corrected.** **Resident #16's orders have been corrected. The CNA assignment sheet has been corrected. The alarming seat belt will be monitored every shift for 2 weeks, 5 times weekly for 2 weeks and weekly for 2 weeks.** **Resident #18 receives cottage cheese for lunch and dinner daily.** **The Dietary Service Manager has added the physician's order for cottage cheese to the diet card and meal slips. .** **The Dietary Service Manager shall monitor at least 2 meals services 5**	

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F 282	Continued From page 17 5. The clinical record for Resident #15 was reviewed on 1/21/11 at 10:40 A.M. Diagnoses included, but were not limited to, heart disease, atrial fibrillation, depressive disorder, obesity, and edema. A. On 9/22/10, the consulting psychiatrist ordered "Discontinue Cymbalta [an antidepressant medication] 30 mg. [milligrams]. New order: Start Cymbalta 60 mg." The consultant wrote a progress note, dated 11/24/10, indicating "... Staff reports she is often tearful, however these episodes have decreased since Norco [a pain medication] instituted. I had suggested dose increase to Cymbalta to 60 mg. every A.M. in past month, but she is still on 30 mg. daily. Will once again recommend increasing Cymbalta to 60 mg. every A.M." On 11/24/10, an order for Cymbalta 60 mg. was written. The October and November, 2010 M.A.R. [Medication Administration Record] indicated the resident received the 30 mg. of Cymbalta from 10/1 through 11/24/10. B. The December 2010 physician order recap [recapitulation] sheet listed an order for Metoprolol [a blood pressure medication], 25 mg.--"Take 1/2 tablet (12.5 mg.) daily. Hold for SBP [systolic blood pressure] < [less than] 100, HR [heart rate] < 60." The medication was scheduled for 8:00 A.M. daily. The October, November, and December, 2010, and the January 2011 M.A.R. had the heart rate documented at the time the medication was	F 282	**days a week to ensure resident's receive diets as ordered.** **Medication changes and any parameters ordered will be monitored through the IDT morning meeting.** **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.**	

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F 282	Continued From page 18 administered. A blood pressure measurement, to determine if the systolic blood pressure was less than 100 in order to hold the medication, was not documented. On 11/11/10, the physician wrote an order for a weekly blood pressure check, and was scheduled for the "6-2" [6:00 A.M. to 2:00 P.M. shift]. The November 2010 M.A.R. had blood pressures documented for 11/5, 11/12, and 11/19. No exact time of the blood pressure check was documented. A box for a blood pressure check on 11/26 was blank. The December 2010 M.A.R. had blood pressures documented for 12/4, and 12/11. The time the blood pressure check was done was not documented. Boxes for a blood pressure checks on 12/18 and 12/23 were blank. In an interview on 1/21/11 at 11:45 A.M., L.P.N. #1 indicated blood pressures were taken in the morning, but did not indicate at what time or where it was recorded. The nurse indicated she did not take the blood pressure before administering the medication. In an interview on 1/24/11 at 10:00 A.M., the Director of Nursing indicated blood pressure checks were supposed to be documented on the MAR. At the final exit on 1/24/11 at 4:00 p.m., no additional documentation related to blood pressure checks was provided for review. 6. The clinical record for Resident #18 was reviewed on 1/19/11 at 9:40 A.M. Diagnoses	F 282	**While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.** **Date of Compliance: February 23, 2011.** **F323** **It is the policy of this facility to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** **<u>What corrective action will be done by the facility?</u>** **On February 16, 20111 the nursing staff shall receive inservice/education on the**	

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F 282	Continued From page 19 included, but were not limited to, diabetes, multiple strokes with dysphagia (difficulty swallowing) and contractures, dementia, nephritis, chronic kidney disease, and history of a transurethral resection of the prostate surgery. An acute care hospital discharge summary, dated 2/17/10, indicated "... U.T.I. [urinary tract infection]--would consider urology consult since this is patient's 4th admit in last 9 months for U.T.I.. Acute on chronic renal failure...." A. On 10/21/10, the physician ordered a U.A. [urinalysis] and C. & S. [culture and sensitivity] to determine if the resident had a urinary tract infection. On 10/24/10, the physician ordered Septra D.S. [an antibiotic] for 7 days, and a repeat of the U.A. No date to repeat the U.A. was given. In an interview on 1/21/11 at 9:15 A.M., the Director of Nursing indicated a "repeat U.A." order "usually means" to do a U.A. following the course of antibiotic medication. For the order on 10/24/10, a repeat U.A. should have been done on either 10/31 or 11/1/10. "Nurse's Notes" progress notes had no documentation a U.A. was done until 11/6/10, at 6:00 A.M.--"... U.A. obtained, lab notified." On 11/8/10, the physician ordered another antibiotic for 10 days, with a repeat U.A., and C. & S. No date for the repeat was indicated. The repeat urine test, if following the course of the antibiotic, should have been done on 11/18 or 11/19/10. There was no laboratory report indicating a U.A.	F 282		

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F 282	Continued From page 20 was obtained on either of those dates. On 11/17/10, the physician ordered a repeat U.A. on 11/21/10, and that urine test was done. B. On 12/29/10, the physician ordered "Cottage cheese at lunch and supper." On 1/20/11 at 12:15 P.M., the resident was observed in the main dining room for the lunch meal. There was no cottage cheese on the resident's lunch meal tray, and the order to give at lunch and supper was not marked on the meal slip. A C.N.A. who was feeding the resident indicated the resident received puree food, but did not have any puree cottage cheese with his meal. In an interview on 1/21/11 at 9:00 A.M., Dietary Aide #4 indicated she did bring the puree cottage cheese to Resident #18 later during the lunch meal the day before, after the C.N.A. came to the kitchen to ask about it. The Dietary Aide indicated she had forgotten it.	F 282	**importance of ensuring safety devices are in place as ordered, turned on and functioning.** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **No other residents were affected by the alleged deficient practice.** **On February 16, 20111 the nursing staff shall receive inservice/education on the importance of ensuring safety devices are in place as ordered, turned on and functioning.**	
F 323 SS=D	3.1-35(g)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	**All alarms used will be kept on an "alarm-monitoring log" and reflected on the care plan.** **The CNAs will check each resident's personal/bed/chair alarm every shift for proper functioning. Any malfunction shall**	

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	155211	A. BUILDING _____ B. WING _____	01/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT LEBANON	1685 PERRY WORTH RD LEBANON, IN 46052

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F 323	Continued From page 21 by: Based on observation, interview and record review, the facility failed to ensure that an alarmed self-release seat belt was provided, and that a pressure pad alarm was turned on, for 2 of 5 residents who had a risk for, or history of, falls; in a survey sample of 12 residents reviewed. [Residents #16 and #21] Findings include: 1. The clinical record for Resident #21 was reviewed on 1/20/11 at 2:40 P.M. The resident was admitted on 1/7/11 with diagnoses which included, but was not limited to, dementia with behavior disturbance, hypertension, degenerative joint disease, depression, and cardiac dysrhythmia with a pacemaker. Physician admission orders on 1/7/11 included, but were not limited to, pressure sensitive alarm on bed. A physician progress note, dated 1/12/11, indicated '... Fell this A.M. No injury...." A note on 1/17/11 indicated "... Patient fell 2 times today...." On 1/19/11 at 1:45 P.M., Resident #21 was observed in bed, with her eyes open. In an interview, the resident indicated she was not sure what she was supposed to be doing, but "guessed" she would "just wait." A pressure pad alarm cord was observed to stretch from the alarm unit mounted on the back of a wheelchair next to the bed, to the pad underneath the resident. The alarm unit was observed to turned to the "Off" position. At 2:30 P.M., the resident was observed coming out of her room. As she	F 323	**be reported to the charge nurse and will be documented on the "alarm-monitoring log".** **Any alarm that is noted to have a malfunction, other than the need for a replacement battery, shall be taken out of service immediately and given to the Director of Nurse's or Administrator. Any other type of alarm may be used for a replacement until such time that a replacement like the original alarm is obtained.** **CNA assignments sheets have been audited to ensure residents with alarms are identified. CNA assignment sheets will be updated to reflect new orders and changes to orders for alarms as new orders are received.** **<u>3.What measures will be put into place to ensure this practice does not recur?</u>** **All alarms used will be kept on an**	

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F 323	Continued From page 22 stood in the doorway, L.P.N. #1 passed by and asked if she need some assistance. There was no alarm sounding in the room from the pressure pad alarm. On 1/20/11 at 10:40 A.M., the resident was observed in bed. She was awake, and indicated she thought she was going to get a shower. The pressure pad alarm unit was hung by a web strap over a knob on the headboard. The cord ran from the unit to the pad under the resident. The alarm was turned to the "Off" position. On 1/20/11 at 11:05 A.M., the resident was observed sitting on a beside commode across the room from her bed. L.P.N. #1 was in the room and told C.N.A. #2 "I found her up walking." 2. The clinical record of Resident #16 was reviewed on 1/24/11 at 10:00 A.M. Diagnoses for Resident #16 include, but were not limited to, bipolar depression, dementia, Macular degeneration and osteoarthritis. A Pre-Restraining Assessment for a self-releasing seatbelt, dated 11/10/10, indicated Resident #16 falls forward, was unsteady on her feet, loses her balance and had a history of falls. A physician's order, dated 11/10/10, indicated "D/C pressure alarm for chair et [and] use self-releasing seat belt alarm while up in w/c [wheelchair]." During an observation, on 1/21/11 at 2:00 P.M., Resident #16 was observed sitting in her wheelchair, in her room. The seatbelt was open, with the ends laying along the Resident's upper thighs. The seat belt alarm was not sounding.	F 323	**"alarm-monitoring log" and reflected on the care plan.** **The CNAs will check each resident's personal/bed/chair alarm every shift for proper functioning. Any malfunction shall be reported to the charge nurse and will be documented on the log.** **Any alarm that is noted to have a malfunction, other than the need for a replacement battery, shall be taken out of service immediately and given to the Director of Nurse's or Administrator. Any other type of alarm may be used for a replacement until such time that a replacement like the original alarm is obtained.** **CNA assignments sheets have been audited to ensure residents with alarms are identified. CNA assignment sheets will be updated to reflect new orders and changes to orders for alarms as new orders are received.**	

In addition to the above the Director of Nurse's or designee will review the "alarm-monitoring logs" for completeness. The Director of Nurse's or designee will also conduct random alarm checks daily on varying shifts to ensure alarms are in place, turned on and functioning.

If the DON or designee finds that a resident's "alarm-monitoring log" is incomplete or that an alarm is in the off position, the Director of Nurse's or designee will make sure that the resident's needs are taken care of and then ensure the alarm is in the on position and functioning.

Once that is assured, the DON will re-train any nursing staff involved and will dispense progressive disciplinary action, up to and including termination, for continued instances of noncompliance.

The results of the Director of Nurse's or designee review of the alarm-monitoring logs and daily random alarm checks will be documented using QA Audit tool F- 323.

4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Director of Nurse's or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the DON or designee, who will report on these recommendations at the next QA&A Committee meeting.

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F 323	Continued From page 23 A Care Plan, dated 11/11/10, indicated: "Fall: staff found me on floor. I frequently turn off the alarm box and attempt to self transfer. I have dementia and poor safety awareness. I have had multiple falls, I have a self releasing alarm seatbelt of which I am able to release on command. I have a bed in low position." During an interview on 1/24/11 at 10:30 A.M., the Director of Nursing indicated that at the time of the observation on 1/21/11 at 2:00 P.M., the seat belt did not have an alarm. The alarm for the seatbelt had to be ordered and Nursing was not notified when the alarm had come in. It had now been placed on the wheelchair. 3.1-45(a)(2)	F 323	**While the process of the DON reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.** **Date of Compliance: February 23, 2011** **F356**	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	**It is the policy of this facility to post nurse staffing data as specified on a daily basis at the beginning of each shift, readily accessible to resident and visitors.** **What corrective action will be done by the facility?** **The daily staffing for nursing was posted in prominent locations on units #100 and units #200 on January 21, 2011. The posting includes, name of facility, current date, resident census, the total**	

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F 356	Continued From page 24 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that proper staffing information was posted on 3 of 5 survey days, and was accessible to residents and visitors. Findings include: During group interview on 1/19/11 at 10:30 A.M., the 9 residents present indicated they did not know where staffing information was posted. The environmental tour was conducted on 1/20/11 between 2:00 and 2:40 P.M. accompanied by the Assistant Administrator and the Maintenance Supervisor. During the tour, the required staffing information was not observed to be posted. During daily conference on 1/20/11 at 3:45 P.M., the Assistant Administrator and Director of Nursing indicated the staffing information had been taken down during recent renovations of the building and had not put them back up on the wall yet.	F 356	**number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **No other residents were affected.** **3.What measures will be put into place to ensure this practice does not recur?** **During daily and frequent administrative rounds the Administrator or designee will monitor 5 days per week to ensure the daily staffing for nursing is posted in prominent locations on units #100 and units #200, including, name of facility, current date, resident census, the total number and the actual hours**	

worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.

If during daily and frequent administrative rounds the Administrator or designee notes that the daily staffing for nurses is not posted he/she shall complete the form immediately and post it at the nurse's stations.

Results of the daily staffing for nurse's posting shall be documented on the morning stand-up form at the IDT meeting 5 days per week.

<u>4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u>

The Administrator or designee will bring the results of the audits to the QA&A Committee meeting. The committee will review the

results and provide recommendations for process improvement where needed. Any recommendations for improvement will be followed by the Administrator or designee, who will report on these recommendations at the next QA&A Committee meeting.

While the process of the daily and frequent administrative rounds is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.

Date of Compliance: February 23, 2011

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F 356	Continued From page 25 On on 1/21/11 at 10:00 A.M., a clear free-standing plastic document holder with the current date and the staffing information for each wing inserted inside was observed on the counters at each of nursing stations. 3.1-13(a)	F 356	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 2/23/2011**	
F9999	FINAL OBSERVATIONS STATE FINDINGS 3.1-14 PERSONNEL 1. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an employment physical examination was completed within 1 month prior to employment, and conducted by a medical professional whose scope of practice allows the performance of such exams, for 6 of 7 new employees reviewed who were hired between 9/24/10 and 12/2/10. [Employees #6, #7, #8, #9,	F9999	**3.1-14 PERSONNEL** **It is the policy of this facility ensure an employment physical examination was completed within 1 month prior to employment, conducted by a medical**	

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F9999	Continued From page 26 #10, and #11] Findings include: Completed "Employee Records" [State Form 5440] forms were provided by the Administrator following entrance on 1/18/11. The forms listed all employees currently employed by the facility. A random sample of seven employee files were selected for review. The following six employees had a physical examination that was completed after their start date, and/or was conducted by someone other than a medical professional whose scope of practice allowed the performance of such exams [i.e. Medical Doctor, Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist]: A. R.N. #6 was listed with a "Start Date" of 10/10/10. A physical examination form was dated as completed on 10/12/10, and was signed by an R.N. In an interview on 1/24/11 at 11:00 A.M., the Business Office Manager, who was responsible for maintaining the personnel files, identified the R.N. who signed the examination form as the previous Director of Nursing. She indicated that as far as she knew, that nurse did not have any of the above listed credentials. B. L.P.N. #7 was listed with a "Start Date" of 11/19/10. A physical examination form was dated as completed on 11/19/10, and was signed by an R.N. In an interview on 1/24/11 at 11:00 A.M., the Business Office Manager, who was responsible	F9999	**professional whose scope of practice allows the performance of such exams.** **1.What corrective action will be done by the facility?** **Facility staff Registered Nurse's and the facility Director of Nurse's no longer complete new employee physicals. All new employee physical examinations shall be performed by the facility Medical Director.** **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **The Business Office Manager or designee shall review the personnel file of new employee's prior to orientation to ensure the physical examination is complete, and was completed by the Medical Director.**	

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F9999	Continued From page 27 for maintaining the personnel files, identified the R.N. as a current employee in the facility. She indicated that as far as she knew, the nurse did not have any of the above listed credentials. C. Nurse Aide #8 was listed with a "Start Date" of 11/1/10. A physical examination form was dated as completed on 10/29/10, with an unreadable signature. In an interview on 1/24/11 at 11:00 A.M., the Business Office Manager identified the signature as an L.P.N. She indicated the L.P.N. had been the facility's M.D.S. coordinator, but no longer worked at the facility. D. Dietary Aide #9 was listed with a "Start Date" of 9/24/10. A physical examination form was dated as completed on 9/22/10, and was signed by an R.N. In an interview on 1/24/11 at 11:00 A.M., the Business Office Manager, who was responsible for maintaining the personnel files, identified the R.N. who signed the examination form as the previous Director of Nursing. She indicated that as far as she knew, that nurse did not have any of the above listed credentials. E. Housekeeping Aide #10 was listed with a "Start Date" of 10/10/10. A physical examination form was dated as completed on 10/12/10, and was signed by an R.N. In an interview on 1/24/11 at 11:00 A.M., the Business Office Manager, who was responsible for maintaining the personnel files, identified the R.N. who signed the examination form as the previous Director of Nursing. She indicated that	F9999	**The Business Office Manager or designee shall complete a "personnel file audit checklist" for all new employee's prior to the new employee starting orientation.** **If the Business Office Manager or designee identifies a new employee physical examination form that was not completed or, signed as completed by an RN, that employee will not be allowed to work until the employee physical examination is completed by the Medical Director.** **3.What measures will be put into place to ensure this practice does not recur?** **As stated above, the Business Office Manager or designee shall review the personnel file of new employee's prior to orientation to ensure the physical examination was completed and completed by the Medical Director. If the Business Office Manager or**	

designee identifies a new employee physical examination form that was not completed or, signed as completed by an RN that employee will not be allowed to work until the physical examination is completed by the Medical Director.

The Business Office Manager or designee shall complete a "personnel file audit checklist" for all new employee prior to the new employee starting new employee orientation.

<u>4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u>

The Business Office Manager or designee will bring the results of the "personnel file audit checklist" to the QA&A Committee meeting. The committee will review the results and provide recommendations for process

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F9999	Continued From page 28 as far as she knew, that nurse did not have any of the above listed credentials. F. Social Service Director #11 was listed with a "Start Date" of 12/2/10. A physical examination form was dated as completed on 12/31/10, and was signed by a physician. In the interview on 1/24/11 at 11:00 A.M., the Business Office Manager indicated she had been told that any licensed nurse could perform the employment physical examination. 3.1-14(t)	F9999	**improvement where needed. Any recommendations for improvement will be followed by the Business Office Manager or designee, who will report on these recommendations at the next QA&A Committee meeting.** **While the process of the Business Office Manager reviews is ongoing the documentation of the reviews will continue thru the next 30 days. Once that time is completed the QA&A Committee will determine the continued frequency of review documentation.** **Date of Compliance: February 23, 2011.**	